

**1. TO BE COMPLETED BY EMPLOYEE/INSURED**

Surname: ..... First Name: ..... Date of Birth: (dd/mm/yy) .....

Patient's Name: ..... Relationship: ..... Date of Birth: (dd/mm/yy) .....

When did the symptoms of the ailment first appear?: .....

Have you ever had this ailment before? If yes, state when and describe: .....

**CAUSE OF CONDITION:**

Is Patient's condition related to: (a) Employment?  Yes  No  
 (b) Auto Accident?  Yes  No  
 (c) Other Accident?  Yes  No

Details: .....

If "Yes", State Name of Employer's Insurer: .....

**CO-ORDINATION OF BENEFITS:**

Is Patient covered by any other plans, which provide benefits for this injury or sickness?  Yes  No If "Yes", give:

(a) Name of Insurance Company: .....

(b) Insured's Name: .....

(c) Name of Group or Company insured under: .....

**ASSIGNMENT OF INSURANCE BENEFITS:**

I hereby authorise and direct you to pay to ..... all benefits due to me or my covered dependant(s) as a result of this claim.

I understand that I am financially responsible for charges not covered by the policy

Insured's Signature: ..... Date: (dd/mm/yy) .....

**AUTHORISATION:**

I/we hereby certify that the forgoing answers are true and correct to the best of my/our knowledge and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish detailed information (including full copies of their records) regarding this claim.

Insured's Signature: ..... Spouse's Signature: ..... Date: (dd/mm/yy) .....

**2. TO BE COMPLETED BY HUMAN RESOURCES DEPT.**

Policy Holder: ..... Policy No.: ..... Employee Certificate No.: ..... Effective Date: (dd/mm/yy) .....

Has employee made claim for Workmen's Compensation?  Yes  No Is he/she entitled to such benefits?  Yes  No

Company Stamp: ..... Administrator's Signature: ..... Date: (dd/mm/yy) .....

**3. TO BE COMPLETED BY OPTICIAN/OPHTHALMOLOGIST/OPTOMETRIST:**

Patient's Name: .....

Date of Birth: (dd/mm/yy) .....

Diagnosis	Date of Service (dd/mm/yy)	Description of Service	Charge \$
<input type="radio"/> SINGLE <input type="radio"/> BI-FOCAL <input type="radio"/> LENTICULAR <input type="radio"/> CONTACT LENSES			

Total

I hereby certify that the above services as indicated by date have been completed

Official Stamp: ..... Signature of Optician/Ophthalmologist/Optomtrist: ..... Date: (dd/mm/yy) .....

**4. TO BE COMPLETED BY PHYSICIAN/HEALTH PROVIDER:**

Patient's Name: .....

Date of Birth: (dd/mm/yy) .....

Date of Visit or Service (dd/mm/yy)	Diagnosis/ICD Code	Visit Fee	Type of Visit	Service Rendered (drugs, injections, tests, supplies)	Cost	Further Services Recommended

MEDICAL

Date of first symptoms: (dd/mm/yy) .....

Has patient been previously treated for this condition?  Yes  No

Date of the first consultation for this condition: (dd/mm/yy) .....

If "Yes", give date: (dd/mm/yy) .....

Was patient referred?  Yes  No

If "Yes", state name of referring doctor: .....

**SURGICAL PROCEDURES:**

Date of Surgery: (dd/mm/yy) ..... Surgeon's Fee: \$ .....

Describe Procedure(s) Performed: ..... Asst. Surgeon's Fee: \$ .....

..... Anaesthetist's Fee: \$ .....

**MATERNITY:**

Date Pregnancy Commenced: (dd/mm/yy) ..... Date of Delivery or Termination: (dd/mm/yy) .....

Type of Delivery: ..... Obstetrical Fee: \$ .....

I hereby certify that the above services as indicated by date have been completed

Official Stamp: ..... Signature of Doctor/Health Provider: ..... Date: (dd/mm/yy) .....

**5. TO BE COMPLETED BY DENTIST:**

Patient's Name: .....

Date of Birth: (dd/mm/yy) .....

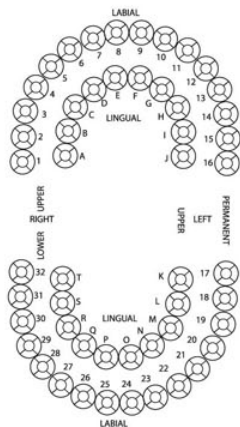
DENTIST: ..... TEL No: .....

(a) Is treatment a result of occupational illness or injury?  Yes  No (If "Yes", details) .....

(b) Is treatment a result of auto accident?  Yes  No .....

(c) Other accident?  Yes  No .....

(d) Orthodontic Treatment?  Yes  No .....



**LIST OF SERVICES (USE CHARTING SYSTEM SHOWN)**

Date of Visit or Service (dd/mm/yy)	Tooth # or Letter	Surface(s)	Description of Service	Charge \$

DENTAL

I hereby certify that the above services as indicated by date have been completed

Official Stamp: ..... Signature of Dentist: ..... Date: (dd/mm/yy) .....